Bureau of Insurance

A Report to the Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature

Review and Evaluation of LD 403, An Act to Provide Health Insurance Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures for Certain Vulnerable Persons

May 9, 2001

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I. Executive Summary

The Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature directed the Bureau of Insurance to review LD 403, An Act to Provide Health Insurance Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures for Certain Vulnerable Persons. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of MMC Enterprise Risk Consulting, Inc. (MMC) and the Maine Bureau of Insurance (the Bureau).

The bill would amend sections of Maine law pertaining to individual and group health insurance plans. Appendix A includes the proposed amendments to the applicable sections of Maine law. The bill requires that health insurers and HMOs provide coverage of general anesthesia and associated facility charges for dental procedures rendered in a hospital for certain eligible enrollees whose health is compromised and for whom general anesthesia is medically necessary. The bill does not require coverage for charges for the dental procedure itself. Under the bill the insurer may require prior authorization for general anesthesia and associated charges in the same manner that prior authorization is required of other covered diseases or conditions. Eligible enrollees include:

- Patients, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;
- Patients demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation, or allergy;
- Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth, or other increased oral or dental morbidity; and
- Patients who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

One pediatric dentist estimates that 125 to 300 pediatric patients could benefit annually

from the use of general anesthesia, although some of these patients would not be covered by LD 403 because they are covered by self-insured plans or by Medicaid or are uninsured. Eligible adults with severe medical or psychological conditions would add to the number of patients affected annually. Our assumption is that fewer than 500 Maine residents would require this service annually. Similar legislation has been passed in twenty-four states. In many states, the legislation allows insurance plans to limit coverage to pediatric dentists or dentists with hospital privileges. Nebraska's recent law (year 2000), like LD 403, allows insurers to apply deductibles, coinsurance, network requirements, and prior authorization as specified for medical services covered under a medical plan. LD 403 allows health plans to require prior authorization for general anesthesia rendered in a hospital in the same manner that prior authorization is required for other covered diseases or conditions.

In twenty-three of the twenty-four states, the mandate applies to health plans. New Hampshire is the one exception where the mandate applies to both medical and dental insurance. One reason for this may be that more individuals are insured under health plans than dental plans. Dental plans are generally only available to individuals (and their dependents) who work for employers who offer dental insurance as a fringe benefit. Dental plans are not typically sold to individual purchasers. Health plans have the needed administrative capacity and contractual arrangements for reimbursing hospitals and anesthetists. It is unlikely that dental insurers would have this capacity and the required contractual arrangements. Another reason is that the cost of general anesthesia provided in a hospital is very costly in comparison to procedures typically covered under dental plans. As a result applying this mandate to dental plans would have a much more significant impact on dental premiums as opposed to health plan premiums. Furthermore, premiums for medical insurance are approximately 9 times those for dental insurance and therefore the extra cost for this benefit would be a much more significant percentage of the premium for dental insurance.

A survey of the major health insurers in Maine indicates that two out of the six surveyed currently cover general anesthesia provided in a hospital for dental services provided to children and adults when warranted by the severity of the person's medical or psychological problems. The insurers surveyed include Aetna U.S. Healthcare, Anthem Blue Cross Blue Shield of Maine, CIGNA, Harvard Pilgrim Health Care, United Healthcare and Maine Partners Health Plan. For the health plans that do not cover the benefits that are mandated under LD 403, the additional premium estimated to cover the added benefit and administrative cost is .05%. One insurer expressed concern about being

able to identify the qualified claims. Each claim submitted will require a manual review to confirm that the defined criteria have been met. Health insurers, that currently cover benefits similar to those stipulated in the LD 403, have expressed the concern that the language allows for substantial interpretation. This could lead to increased utilization for those heath plans that are presumed to be in current compliance with the proposed mandate.

The magnitude of this premium increase by itself would not seem sufficient to move health insurance purchasers to discontinue coverage. However, recent average annual premium increases for health insurance have exceeded 10% for employer groups. Individual annual rate increases have been as high as 64%.[1] The premium increase estimated for LD 403 when combined with large renewal increases would intensify the consumer's sensitivity to health insurance costs.

LD 403 could make a significant difference in the use of dental services for the population insured under health plans that do not cover general anesthesia for these services. Charges for general anesthesia for dental services are estimated to be $740 for the anesthesia and $1,846 for the hospital facility according to the testimony of one Pediatric Dentist. The total cost would be approximately to $2,586 per incidence. This could be a financial hardship for some individuals. Proponents of LD 403 note that the lack of needed dental services for this population may lead to serious medical problems if the unattended dental conditions interfere with getting proper nutrition or aggravate infection. Thus, LD 403 could have a significant effect on the health of the small population covered by the bill.

[1] White Paper: Maine's Individual Health Insurance Market, Updated January 22, 2001

II. Background

The Joint Standing Committee on Banking and Insurance of the 120th Maine Legislature directed the Bureau of Insurance to review LD 403, An Act to Provide Health Insurance Coverage for General Anesthesia and Associated Facility Charges for Dental Procedures for Certain Vulnerable Persons. The review was conducted using the requirements stipulated under 24-A M.R.S.A., §2752. This review was a collaborative effort of MMC Enterprise Risk Consulting, Inc. and the Maine Bureau of Insurance.

The bill would amend sections of Maine law pertaining to individual and group health insurance plans. Appendix A includes the proposed amendments to the applicable sections of Maine law. The bill requires that health insurers and HMOs provide coverage of general anesthesia and associated facility charges for dental procedures rendered in a hospital for certain eligible enrollees whose health is compromised and for whom general anesthesia is medically necessary. The bill does not require coverage for charges for the dental procedure itself. Under the bill the insurer may require prior authorization for general anesthesia and associated charges in the same manner that prior authorization is required of other covered diseases or conditions. Eligible enrollees include:

- Patients, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

- Patients demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation, or allergy;

- Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth, or other increased oral or dental morbidity; and

    - Patients who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

Dental insurance may cover general anesthesia for certain procedures. Dental insurance is available to employees of firms that sponsor this fringe benefit. However, dental insurance is not generally available to individual purchasers. There are very significant differences in the comprehensiveness of the benefits provided under dental insurance plans provided by employers.

From the perspective of at least one proponent, LD 403 is primarily intended for circumstances where an individual does not have dental coverage or where the dental coverage does not require coverage of general anesthesia. LD 403 would not apply to general anesthesia administered in a dental office even if the dentist had the proper qualifications and equipment to administer the anesthesia. LD 403 would require the medical insurance contract to cover the charges for general anesthesia if administered in a hospital even if an individual's dental insurance covers this service. One of the health insurers surveyed indicated that coordination of benefits is applied when members have dental insurance that covers general anesthesia. Either the health plan or the dental plan may be the primary payer as determined by the standard rules for recovery. The rules would designate the health plan as the primary payer in approximately 50% of the cases. The health plan also indicated that opportunities for coordination of benefits were scarce due the low prevalence of dental plans that cover general anesthesia in a hospital.

A representative of the Maine Dental Association, a proponent of LD 403, testified that a small number of special circumstances require that a patient use general anesthesia, such as infants with Baby Bottle Tooth Decay and mentally handicapped persons who do not have the capability of cooperating. If an individual does not have dental insurance or if their dental insurance does not cover general anesthesia for routine dental care, the dentist would either have to use local anesthesia or bill the patient for the general anesthesia. A representative of the Maine State Chamber of Commerce, an opponent, testified that their membership is concerned with the rising cost of health care insurance. There is a concern that increases due to mandated benefits on top of already increasing premiums will cause employers to drop their coverage, which will increase the number of uninsured Maine residents.

III. Social Impact

A. Social Impact of Mandating the Benefit

1. The extent to which the treatment or service is utilized by a significant portion of the population.

One pediatric dentist estimated that from 125 to 300 dental pediatric patients would require general anesthesia annually in the State of Maine. MMC estimates that a smaller number of adults would qualify for and require general anesthesia for a dental procedure because the mentally handicapped population is smaller than the number of children. In total fewer than 500 Maine residents are expected to use the proposed mandated benefit in a given year.

2. The extent to which the service or treatment is available to the population.

General anesthesia for dentistry is available to the population at this time. General anesthesia is available from some dentist or oral surgeons in dental offices and from dentists who have hospital privileges for dental procedures either because they have the needed permit or through the use of an anesthesiologist with privileges at the hospital.

3. The extent to which insurance coverage for this treatment is already available.

Dental insurance may cover general anesthesia for certain procedures. Dental insurance is available to employees of firms that sponsor this fringe benefit. However, dental insurance is not typically available to individual purchasers. There are very significant differences in the comprehensiveness of the benefits provided under dental insurance plans provided by employers. Approximately 13% of the employers who provide dental insurance offer plans that are limited to preventative care (routine check ups and cleanings).[2] Based on a national survey of employers, 95% of employers with 10 or more employees offer some form of

[2] Mercer/Foster Higgins, National Survey of Employer-sponsored Health Plans 1999

dental coverage.[3]

Some medical insurance contracts do not provide coverage for any costs for services associated with non-covered dental procedures. Other medical plans provide such coverage when dental procedures cannot be safely provided in a dental office. Examples where general anesthesia may be covered under these health plans include medically or psychologically problematic children and individuals with cardiac conditions.

Medicaid covers general anesthesia for dentistry for Medicaid eligible individuals.

4. *If coverage is not generally available, the extent to which the lack of coverage results in a person being unable to obtain the necessary health care treatment.*

If an individual's medical or dental policy does not cover this service they would be able to obtain the treatment, but would have to pay for it themselves. Medicaid would cover general anesthesia for certain low-income individuals.

5. *If coverage is not generally available, the extent to which the lack of coverage involves unreasonable financial hardship.*

Assuming that an individual's health plan and dental plan did not cover the cost of anesthesia and associated facility charges for dental procedures, the individual would have to pay the cost of the anesthesia and associated facility charges, if the procedure was done in a hospital.

These charges are estimated to be $740 for the anesthesia and $1,846 for the hospital facility according to the testimony of one Pediatric Dentist. The total cost may then be up to $2,586 per incidence. A comparable estimate, derived from MMC's database is $3,100. This could be considered a financial hardship for some individuals.

6. *The level of public demand and the level of demand from providers for this treatment or service.*

[3] Mercer/Foster Higgins, National Survey of Employer-sponsored Health Plans 1999

The American Academy of Pediatric Dentistry (AAPD) supports the need for general anesthesia for dental procedures under the circumstances covered by this bill.

7. *The level of public demand and the level of demand from the providers for individual or group coverage of this treatment.*

The American Academy of Pediatric Dentistry (AAPD) supports the need for insurance coverage for general anesthesia for dental procedures under the circumstances covered by this bill, since it is generally excluded under medical contracts.

8. *The level of interest in and the extent to which collective bargaining organizations are negotiating privately for the inclusion of this coverage by group plans.*

No information is available.

9. *The likelihood of meeting a consumer need as evidenced by the experience in other states.*

Similar legislation has been passed in 24 states and Puerto Rico. These are California, Colorado, Connecticut, Florida, Georgia, Indiana, Idaho, Kansas, Louisiana, Maryland, Minnesota, Montana, Missouri, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, Oklahoma, Puerto Rico, South Dakota, Tennessee, Texas, Virginia, and Wisconsin. Many states indicate that insurance plans can limit coverage to providers to pediatric dentists or other dentists with hospital privileges.

Research done by the American Academy of Pediatric Dentistry indicates that the impact on medical insurance plan premiums reported in other states included increases of:

Mississippi - .05%
Louisiana - .013%
Alabama - .97%
Texas – 0%

Many of other states limit coverage to children under a specific age. Appendix C provides information on the scope of some other state laws.

10. *The relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

State agencies did not provide findings pertaining to the proposed legislation.

11. *Alternatives to meeting the identified need.*

This bill requires health insurers and health maintenance organizations to provide the coverage for anesthesia and associated facility charges for dental procedures rendered in a hospital for certain eligible enrollees. If dental insurance covers the procedure itself, it may be possible to require the dental policy to provide the coverage for anesthesia and associated facility charges. However, dental insurance is only available to individuals who are employed by firms that offer dental insurance that provides comprehensive benefits. Dental insurance is not as widely available as medical insurance. Furthermore, premiums for medical insurance are approximately 9 times those for dental insurance and therefore the extra cost for this benefit would be a much more significant percentage of the premium for dental insurance.[4] In reviewing similar laws in other states, the mandated benefit is applied to medical plans. Our research uncovered only one state that placed this requirement on dental plans. New Hampshire legislation applies to both Dental and Medical plans.

12. *Whether the benefit is a medical or a broader social need and whether it is*

[4] Mercer Foster / Higgins Survey, National Survey of Employer-sponsored Health Plans 1999

inconsistent with the role of insurance and the concept of managed care.

The requirements of LD 403 are not inconsistent with the role of insurance and the concept of managed care. Most health plans currently offer coverage of general anesthesia only when they cover the procedure.

13. *The impact of any social stigma attached to the benefit upon the market.*

There is little or no social stigma attached to having general anesthesia for dental procedures.

14. *The impact of this benefit upon the other benefits currently offered.*

Currently dental procedures may be covered by a dental insurance contract or by medical insurance contract depending on the type of service being rendered. This bill would require a medical insurance policy to provide the coverage for anesthesia and associated facility charges for dental procedures that are not covered by the medical insurance contract.

15. *The impact of the benefit as it relates to employers shifting to self-insurance and the extent to which the benefit is currently being offered by employers with self-insured plans.*

State legislation that imposes benefit mandates will heighten an employer's concern with regard to future costs and make self-insurance a more attractive alternative. The 1998 Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans indicates that 36% percent of the large employers (500 or more employees) in the Northeast self-insure health plans.

Given the double digit annual increases in medical care costs, large employers may be particularly sensitive to any legislation that places limits on managed care and increases the cost of health care.

No information is available as to the extent to which this benefit is currently being offered by employers with self-insured plans.

16. The impact of making the benefit applicable to the state employee health insurance program.

Based on Anthem Blue Cross and Blue Shield of Maine's plan survey response, the State of Maine Point of Service Plan and COMP-CARE Plan do not currently provide coverage for any costs associated with non-covered dental procedures. Anthem Blue Cross Blue Shield of Maine estimates that LD 403 would have a negligible financial impact on the Maine State Employees Health Insurance Program. MMC's analysis indicates that this cost would be under $50,000 per year.

IV. Financial Impact

B. Financial Impact of Mandating Benefits.

1. The extent to which the proposed insurance coverage would increase or decrease the cost of the service or treatment over the next five years.

General anesthesia and hospital facility cost is not priced separately for dental services. Therefore, insurance coverage for general anesthesia for dental procedures would not be expected to affect the cost of the service.

2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.

LD 403 may increase the inappropriate use of general anesthesia for dental procedures. It is possible that general anesthesia will be used where it is inappropriate, since it is covered by medical insurance. Once a service is covered by insurance there is a possibility of it being inappropriately used since the cost of its use becomes negligible to the patient.

LD 403 would not apply to general anesthesia administered in a dental office even if the dentist had the proper qualifications and equipment to administer the anesthesia. This may result in services being moved from the less expensive setting of a dental office to the more expensive setting of a hospital.

LD 403 would require the medical insurance contract to cover the charges for general anesthesia if administered in a hospital even if an individual's dental insurance covers the general anesthesia if administered in a dental office or covered the hospital-based anesthesia.

This bill does not preclude applying a prior approval process or other utilization review procedures to minimize inappropriate usage.

LD 403 will increase the appropriate use of general anesthesia because the insurance coverage will allow those individuals that need general anesthesia and cannot afford the cost of general anesthesia to receive it. In these cases it will also increase the use of needed dental services when they could not be safely or practically performed without general anesthesia.

3. The extent to which the mandated treatment or service might serve as an

alternative for more expensive or less expensive treatment or service.

The services when used under the mandate will replace the less expensive use of a local anesthetic. It is estimated that the annual number of cases for pediatric use would be between 125 to 300 and the total cases including mentally handicapped and other qualifying individuals would be less than 500. In some of these cases, the less expensive treatment may be possible, but in others the patient would not be able to have the dental procedure unless general anesthesia could be used.

A new painless drilling is available using a laser for cavity treatment. The equipment lists for about $45,000, and it is unclear if this alternative would be priced significantly less than using general anesthesia. Painless drilling would not solve the problem for many eligible patients that are too young, mentally limited or fearful to be cooperative even with a painless procedure.

4. *The methods which will be instituted to manage the utilization and costs of the proposed mandate.*

LD 403 allows health plans to require prior authorization for general anesthesia rendered in a hospital in the same manner that prior authorization is required for other covered diseases or conditions.

5. *The extent to which insurance coverage may affect the number and types of providers over the next five years.*

It is estimated that between 125 and 300 pediatric cases and less than 500 total cases would occur each year. The number of these patients affected by the mandate would be less, since the self-insured, the uninsured and Medicaid recipients are not covered by LD 403. An increase in providers would not be expected for this low volume.

6. *The extent to which the insurance coverage of the health care service or providers may be reasonably expected to increase or decrease the insurance premium or administrative expenses of policyholders.*

This proposed legislation would only impact the health plans that do not currently cover general anesthesia under the prescribed circumstances. For those health plans, the estimated increase is .05 percent. The calculations and assumptions are displayed in Table A.

One of the surveyed health insurers with plans that do not currently cover the mandated benefit estimates that LD 403 would increase the small group premiums by 0.2% to 0.4%. This same insurer estimates premium increase for the individual market to be 1%.

TABLE A
ESTIMATED IMPACT ON HEALTH PLAN PREMIUM

A	Cost of general anesthesia in a hospital setting	$3,100	MMC Database
B	Annual utilization per 1,000 members	.36	Derived from US Census Data and other sources
C	Expected annual cost	$1.12	A x B /1,000
D	Average per member total benefit cost	$2,040	
E	Percent premium increase	.05%	C / D

Health insurers with plans that do not cover this benefit have concerns about being able to identify qualified claims. Each claim submitted will require a manual review to confirm that the defined criteria have been met. Health insurers that currently cover benefits similar to those stipulated in the LD 403 have expressed the concern that the language allows for substantial interpretation. This could lead to increased utilization for those heath plans that are presumed to be in current compliance with the proposed mandate.

7. *The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the cost and benefits of coverage.*

There would not be any additional cost effect beyond benefit and administrative costs.

8. *The impact on the total cost of health care.*

MMC estimates that LD 403 could increase premiums by .05%. Since in many cases general anesthetic for dentistry is not used if it is not covered by insurance due to the cost, total health care cost may increase by an amount less than .05%. There are no other apparent significant costs or savings associated with this proposed legislation.

9. *The effects on the cost of health care to employers and employees, including the financial impact on small employers, medium-sized employers and large employers.*

LD 403 would, on average, increase premiums for health plans that do not currently comply with LD 403, by an estimated 0.05%. Employers will pay this additional premium, as will employees to the extent the cost is passed on through the employee's contribution to the premiums. There is no reason that the estimated percentage premium increase will vary for small employers, medium-sized employers and large employers. This increase will contribute to rising premiums that may cause employers who are too small to self-insure to discontinue offering health insurance to employees. Fewer employees may elect health insurance when confronted with rising premiums.

V. Medical Efficacy

C. The Medical Efficacy of Mandating the Benefit.

1. The contribution of the benefit to the quality of patient care and the health status of the population, including any research demonstrating the medical efficacy of the treatment or service compared to the alternative of not providing the treatment or service.

Individuals that need general anesthesia for dental procedures may go without those services unless insurance coverage for general anesthesia is available. The a potential result of not receiving needed dental services is that the medical condition worsens and can result in the loss of teeth and/or the need for more extensive oral surgery. The availability of general anesthesia will improve the effectiveness of dental care and the general health for these individuals.

Research was cited by proponents of the bill indicating that children with severe decay do not thrive and upon treatment do improve. Severe tooth decay can result in children not eating properly, which causes underdevelopment. With treatment these children can improve and eventually catch up with their normal growth.

2. If the legislation seeks to mandate coverage of an additional class of practitioners relative to those already covered.

a. The results of any professionally acceptable research demonstrating medical results achieved by the additional practitioners relative to those already covered.

LD 403 will not require an additional class of practitioners.

b. The methods of the appropriate professional organization that assure clinical proficiency.

LD 403 will not require an additional class of practitioners.

VI. Balancing the Effects

D. The Effects of Balancing the Social, Economic, and Medical Efficacy Considerations.

1. The extent to which the need for coverage outweighs the cost of mandating the benefit for all policyholders.

The population covered by LD 403 is relatively small. The cost of providing general anesthesia for needed dental care is estimated to be .05% of the total premium for medical plans that do not currently cover this mandate. This premium increase by itself would not seem likely to move health insurance purchasers to discontinue coverage. However, average annual premium increases for health insurance have been in the vicinity of 10% for employer groups. Premiums for individual medical plans have seen increases as high as 64%[5]. The premium increase estimated for LD 403 when combined with large renewal increases would intensify the consumer's sensitivity to health insurance costs. Given that approximately 15.2% of Maine non-elderly residents have no health insurance,[6] the impact of every additional increase including LD 403 is an important consideration.

LD 403 may make a significant difference in the use of dental services for the population covered. The lack of needed dental services for this population can cause serious medical problems if it interferes with getting proper nutrition or if infections spread.

[5] White Paper: Maine's Individual Health Insurance Market, Updated January 22, 2001
[6] The Henry J. Kaiser Family, State Health Facts, April 2001

2. *The extent to which the problem of coverage can be resolved by mandating the availability of coverage as an option for policyholders.*

It is not practical to offer this coverage as an option for individual policyholders. It is only applicable to a relatively small segment of the population. Therefore, only this small segment would request the option, all of whom would use it, resulting in a premium that would be the same as paying for the services on an out-of-pocket basis. Since some medical plans currently provide this benefit, it is available as an option for employers who offer medical plans to employees.

3. *The cumulative impact of mandating this benefit in combination with existing mandates on costs and availability of coverage.*

The Bureau's estimates of the maximum premium increases due to existing mandates and the proposed mandate are displayed in Table B.

TABLE B
MAXIMUM PREMIUM INCREASES

	Group (more than 20 employees)	Group (20 or fewer employees)	Individuals
CURRENT MANDATES			
▪ Fee-for-Service Plans	7.84%	3.94%	3.93%
▪ Managed Care Plans	7.52%	4.02%	3.92%
LD 403			
▪ Fee-for-Service Plans	.05%	.05%	.05%
▪ Managed Care Plans	.05%	.05%	.05%
CUMULATIVE IMPACT			
▪ Fee-for-Service Plans	7.89%	3.99%	3.98%
▪ Managed Care Plans	7.57%	4.07%	3.97%

These increases are based on the estimated portion of claim costs that the mandated benefits represent, as detailed in Appendix B. The true cost impact is less than this for two reasons:

1. Some of these services would likely be provided even in the absence of a mandate.
2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering mental health and substance abuse may reduce claims for physical conditions. Covering social workers may reduce claims for more expensive providers such as psychiatrists and psychologists. Covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. While some studies have estimated much higher costs for mandated benefits, these studies were not based on the specific mandates applicable in Maine and therefore are not relevant. There is no indication that mandated benefits have impacted the availability of health insurance.

VII. Appendices

Appendix B: Cumulative Impact of Mandates

Following are the estimated claim costs for the existing mandates without the reductions:

- ***Mental Health*** - The mandate applies only to groups of more than 20. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. Mental health parity for listed conditions was effective 7/1/96. The 1998 data showed a small increase to 3.43% of total group health claims while 1999 data showed a slight increase to 3.49%. We have used 3.5% as our best estimate for future years.

- ***Substance Abuse*** - The mandate applies only to groups of more than 20 and does not apply to HMOs. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage has shown a downward trend beginning in 1989 and continuing through the most recent data points which were 0.4% for 1998 and 0.39% in 1999. This is probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims have decreased from about 90% of the total to about 56%. We estimate the percentage to remain at about the 0.4% level, although further decreases are possible.

- ***Chiropractic*** - The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the trend has been increasing since 1994. The percentage has increased from 0.84% that year to 1.29% in 1998 and 1.46% in 1999. We therefore estimate 1.6% going forward.

- ***Screening Mammography*** - The amount of claims paid has been tracked since 1992 and generally has been in the range of 0.2% to 0.3%. It was 0.3% in 1998 and 0.31% in 1999 which may reflect increasing utilization of this service. We estimate 0.3% going forward.

- ***Dentists*** - This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.20 per month per individual. We have no more recent estimate. We

include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** - Our report on this mandate indicated that most of the 15 carriers surveyed said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** - Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** - No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) - This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** - Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** - The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our report does not resolve this conflict but states a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** - No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately

$0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** - This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

These costs are summarized in the following table.

Cost of Existing Mandated Health Insurance Benefits

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[7]	0[7]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.1%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[7]	--
1983	Benefits must include for treatment of **alcoholism and drug dependency**.	Groups of more than 20 except HMOs	0.4%	--
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	3.5%	3.5%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	All Contracts	1.6%	1.6%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.3%	0.3%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Perinatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.2%	0.2%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.1%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	.07%	.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.3%	0.3%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	.07%	0

[7] This has become a standard benefit that would be included regardless of the mandate.

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers	All Managed Care Contracts		0.16%
1999	Prescription drug must include **contraceptives**	All Contracts	0.8%	0.8%
1999	Coverage for **registered nurse first assistants**	All Contracts	0	0
2000	Access to **clinical trials**	All Contracts	0.46%	0.46%
2000	Access to **prescription drugs**	All Managed Care Contracts	0	0
Total cost for groups larger than 20:			**7.84%**	**7.52%**
Total cost for groups of 20 or fewer:			**3.94%**	**4.02%**
Total cost for individual contracts:			**3.93%**	**3.92%**

Appendix C: Scope of Similar Laws in Other States

Connecticut (Public Act 99-284), Florida (Title XXXVII, §§ 627.4295 and 627.65755) & New Hampshire (Title XXXVII, §§ 415:18-g and 415:18-h)
…under the age of four who is determined by a licensed dentist, in conjunction with a licensed physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital, or (B) a person who has a developmental disability, as determined by a licensed physician who specializes in primary care, that places the person at serious risk.

California (Insurance Code, § 10119.9) & Georgia (Title 33, § 33-24-28.4)
…7 years of age or younger or is developmentally disabled; An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the insured;
or
An individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.

Indiana (Title27 § 27-8-5-27) & Louisiana (Title 22, R.S. 22:228.7)
The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the insured's condition under general anesthesia constitutes appropriate treatment.

Maryland (Title 15, § 15-828)
… 7 years of age or younger or is developmentally disabled; an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insured; and an individual for whom a superior result can be expected from dental care provided under general anesthesia; or

an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and

an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

Mississippi (Title 83, § 83-9-32)
… mental or physical condition of the child or mentally handicapped adult requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office.

Minnesota (Insurance Laws, § 62A.308), Missouri (Title XXIV, § 376.1225), Virginia (Title 38.2, § 38.2-3418.12) & New Jersey (Title 17, §§ 17:48-6u, 17:48A-7t, 17:48E-35.19; Title 17B, §§ 17B:26-2.1r, 17B:27-46.1u; Title 26, § 26:2J-4.19)
… a child under the age of five; a person who is severely disabled;
or
a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided …

Appendix D: References

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